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Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada

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ABSTRACT

Almost 1.7 million people in the settler colonial nation of Canada identify as Indigenous. Approximately 52 per cent of Indigenous peoples in Canada live in urban areas. In spite of high rates of urbanization, urban Indigenous peoples are overlooked in health care policy and services. Because of this, although health care services are more plentiful in cities as compared to rural areas, Indigenous people still report significant barriers to health care access in urban settings. This qualitative study, undertaken in Prince George, Canada, examines perceived barriers to health care access for urban Indigenous people in light of how colonialism impacts Indigenous peoples in their everyday lives. The three most frequently reported barriers to health care access on the part of the 65 participating health care providers and Indigenous clients of health care services are: substandard quality of care; long wait times; and experiences of racism and discrimination. These barriers, some of which are common complaints among the general population in Canada, are interpreted by Indigenous clients in unique ways rooted in experiences of discrimination and exclusion that stem from the settler colonial context of the nation. Through the lenses of cultural safety and ethical space – frameworks developed by international Indigenous scholars in efforts to better understand and operationalize relationships between Indigenous and non-Indigenous individuals and societies in the context of settler colonialism – this study offers an understanding of these barriers in light of the specific ways that colonialism intrudes into Indigenous clients' access to care on an everyday basis.

Introduction

In the settler colonial nation of Canada, almost 1.7 million people (4.9 per cent) identify as Indigenous, including First Nations, Métis, and Inuit ([Statistics Canada, 2017a](#)). About 45 per cent of Indigenous people are registered under the *Indian Act* and are referred to as “status First Nations” ([Government of Canada, 1985a](#)). It is important to note that the Constitutional division of Indigenous peoples into First Nations, Métis and Inuit overlooks immense cultural diversity. For example, there are over 618 First Nations in Canada, and Indigenous peoples speak over 70 Indigenous languages within 12 distinct language families ([Statistics Canada, 2017a](#)).

The *Indian Act* is a piece of legislation written and implemented in 1876 ([Lavoie et al., 2010](#)). Under the *Indian Act*, portions of land called reserves are set aside “for the exclusive use of an Indian band” ([Hanson, 2009, n.p.](#)). Reserves are provided with primary health care and public health services by the federal government ([Kelly, 2011](#)). Status First Nations people living off-reserve have access to federal coverage for health services that are not covered under provincial insurance plans, such as limited, basic dental work ([Health Canada, 2013](#); [Leck and Randall, 2017](#)). Otherwise, health services for all Indigenous peoples living off-reserve (including rural or urban areas) are provided by the provinces and territories ([Kelly, 2011](#)).

Indigenous peoples in other settler colonial nations have similar spatially-ordered and identity-driven jurisdictional contexts for health care. In the United States, Indian Health Services (IHS) provides health care services to members of federally-recognized tribes or tribal organizations. IHS services are located mainly on reservations, with services in urban areas in only 20 of the 51 states ([Indian Health Service, n.d.](#)). In Australia, Aboriginal Community Controlled Health Organizations (ACCHOs) and government services for Indigenous Australians are together called Aboriginal Medical Services (AMS) ([Gomersall et al., 2017](#)). The latter are primarily available in the Northern Territory and north Queensland ([Gomersall et al., 2017](#)). Eligibility for Indigenous services is primarily based on self-identification ([Australian Bureau of Statistics, 2018](#)).

While reserves in Canada are experiencing population growth, Indigenous

populations in urban areas have also expanded dramatically over the past several decades in Canada and worldwide (Australian Bureau of Statistics, 2018; Snyder and Wilson, 2012). In Canada, about 52 percent of the overall Indigenous population now lives in cities, compared to only about seven per cent in the early 1950s (Kalbach, 1987; Statistics Canada, 2017a). In Australia, 70 per cent of Indigenous peoples live in cities; in New Zealand, 84 per cent; and in the United States, 60 per cent (Snyder and Wilson, 2012). In spite of this, research and policy related to Indigenous health in Canada remain disproportionately focused on rural and reserve areas (Wilson and Cardwell, 2012). In other areas of the world, for example in Australia, much research is being conducted with urban Indigenous populations but without drawing geographical comparisons between urban and other contexts for health outcomes and health care experiences (Nelson et al., 2012; Priest et al., 2017).

Indigenous people in Canada, both on reserve and in urban areas, experience difficulties accessing health care services. On reserves in rural areas, services are few and tend to be understaffed and underfunded (O'Neill et al., 2013). In urban areas where services are more plentiful, Indigenous people report higher rates of discrimination based on Indigenous identity (Browne, 2017; Evans et al., 2014). Research finds that in spite of the generally higher burden of morbidity and mortality among Indigenous people in settler colonial countries such as Canada, the United States, Australia and New Zealand, Indigenous people experience particular barriers to accessing health care services (Marrone, 2007; Wilson et al., 2015).

The barriers encountered by Indigenous people when accessing health care are rooted in the contexts of settler colonialism in which they live; a reality that is generally acknowledged in research (Maar et al., 2009; Reeves and Stewart, 2014), but rarely clearly articulated or analyzed (but see, e.g., Browne, 2017; Maxwell, 2011). To address this gap, the present study draws on two frameworks developed by Indigenous scholars – cultural safety and ethical space – in order to bring settler colonialism into the analysis of Indigenous people's reported barriers to health care.

Focused on the encounter between health care provider and patient, cultural safety draws attention to power imbalances rooted in colonialism that become embedded in the institutions of health care, and highlights the need for clients to feel

safe within this encounter (Dyck and Kearns, 1995; Ramsden and Spoonley, 1994). Studies dealing with cultural safety in Canada investigate how best to implement it in health care services or in policy (Browne et al., 2009b; Wong et al., 2011) or provide examples of culturally safe health care services – often Indigenous-led health organizations (Maar and Shawande, 2010; Reeves and Stewart, 2014).

Ethical space describes a space where world views meet as equals, in which colonial hierarchies of knowledge systems (epistemologies) and world views (ontologies) are countered (Alberta Energy Regulator, 2017; Ermine, 2007a). The space that is made is simultaneously physical, psychological, and social. The concept of ethical space has been applied to a limited extent in health care settings. Barina (2015) uses ethical space to describe how the space of health care “promotes certain habits, practices, representations, and ideals” (p. 100). Brunger et al. (2016) employ ethical space as a model for collaboration in the review of ethics protocols for health research in Indigenous communities. The present study aims to engage with the concept of ethical space in order to examine the impacts of the socio-spatial relations of settler colonialism in the spaces and relations of health care. This is important because Indigenous people's reported barriers to accessing health care are not fully comprehensible without bringing settler colonialism into the analysis. The purpose of this study is thus to provide a critical understanding of urban Indigenous people's access to health care in light of Canada's settler-colonial reality, drawing on cultural safety and ethical space to highlight how settler colonialism informs Indigenous clients' experiences.

Health services access for Indigenous people

Under the Canada Health Act (CHA) (Government of Canada, 1985b), the federal government delivers health care funding to provinces and territories, who then provide services free of charge to residents. The CHA lists five criteria that provinces and territories must meet in order to receive funding, one of which is accessibility, meaning “provid[ing] for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges

made to insured persons or otherwise, reasonable access to those services by insured persons” ([Government of Canada, 1985b](#), n.p.). “Reasonable access” is understood as economic and physical access; the former meaning that clients do not have to pay for medically necessary services covered under provincial public health insurance plans, and the latter defined by the “where and as available” rule, meaning that every insured person will not, for example, have access to identical services in small, remote towns and large urban centres. These rules are intended to preclude discrimination, whether based on fees incurred at the point of service delivery or on identifiers such as age, sex, or racialization ([Health Canada, 2017](#); [Wilson and Rosenberg, 2004](#)).

Thus, the Canadian government provides funding for health care services, but provinces administer and deliver the services. The federal government, however, retains responsibility in much of Canada for providing health care services to status First Nations individuals living on reserve, creating a separate system of health care for a subsection of the Indigenous population. In British Columbia (BC), the First Nations Health Authority has taken over federal responsibility for health services and takes a much more community-centred approach. The impact that this change may have on jurisdictional boundaries between status and non-status, or on-reserve and off-reserve, is still being worked out. Provinces and territories, including BC, are responsible for providing care for non-status Indigenous people as well as status First Nations people accessing services off-reserve, creating a jurisdictional divide between governments ([Shewell, 2016](#)).

In other parts of the world, similar policies govern Indigenous people’s interactions with health care systems. In particular, whether a person is eligible for Indigenous-focused health care services tends to be carefully delineated by both identity and by geography in settler colonial countries, as outlined above ([Champion et al., 2008](#); [Indian Health Service, n.d.](#); [Marrone, 2007](#)).

The general consensus in the literature is that Indigenous people have worse access to quality health care than settler populations around the world, and face a unique set of barriers to access ([Browne et al., 2016](#); [Davy et al., 2016](#)). It is found that Indigenous people have higher rates of hospital admissions for conditions that should be treatable in primary care settings, as well as less access to specialists such as

nephrologists for the treatment of kidney disease (Gao et al., 2008; Kendall, 2007; Shah et al., 2003). Indigenous people living in rural or remote areas in Canada are found to have worse availability of services and less utilization of health care than their urban counterparts; however, Indigenous people in urban areas report more instances of racism or discrimination and less cultural appropriateness of health care services (Browne et al., 2009a; Place, 2012).

In Canada, the role of racism in impeding Indigenous people's access to non-Indigenous-led health services has been well documented (Allan and Smylie, 2015; Browne, 2017; Goodman et al., 2017; Tang and Browne, 2008). For example, Indigenous clients accessing care in an Emergency department in British Columbia reported expecting to be negatively judged by health care providers, before they ever entered the hospital (Browne et al., 2011). Indigenous clients of urban health services in southern British Columbia reported feeling that doctors did not believe them when they expressed their feelings and symptoms (Evans et al., 2014). Deaths of clients within health care settings due to total negligence have also been linked to structural racism that becomes embodied in the behaviour of health care workers (Browne et al., 2017). The need to ensure Indigenous people's safety is emphasized in the literature and related to experiences of racism, as Indigenous peoples experience verbal, implicit, or overt physical violence in health care settings (Cameron et al., 2014; Evans et al., 2014; Kurtz et al., 2008).

The goal of this study is to examine barriers to health care access for Indigenous people in light of the ways in which broader structures of colonialism influence Indigenous people in their everyday lives. Cultural safety and ethical space provide lenses through which to examine these barriers, in order to highlight the individual-level impacts of these broader structures and how they become embedded in the everyday spaces of health care settings.

Methods

This study is located in Prince George, British Columbia (BC), Canada; a city of 82,865 people in the northern interior of BC, of which just under 15 per cent reported

Indigenous identity in 2016 ([Statistics Canada, 2017b](#)). For comparison, Indigenous people in Winnipeg, Manitoba make up 11 per cent of the population, whereas in Toronto and Vancouver proportions are 0.8 per cent and 2.3 per cent, respectively ([Statistics Canada, 2017b](#)). Prince George is within the traditional territory of the Lheidli T'enneh First Nation. In addition, there are 54 different First Nations in northern British Columbia served by the Northern Health Authority, for whom Prince George is the central service area as well as the largest urban centre.

This study followed principles of community-based and decolonizing research, and was guided by a Community Advisory Group consisting of eight health care professionals, researchers, Indigenous Elders (community-recognized knowledge holders) and community leaders in Prince George who provided advice throughout the research process. This was a qualitative research study, involving 15 health care professionals and 50 Indigenous community members who had accessed some form of health care in 29 individual semi-structured interviews and four focus groups (n = 36). Eight of the 15 health care professionals identified as Indigenous; all community members identified as Indigenous. Two participants identified as both health care providers and clients of health care; these two have been counted as Indigenous community members, or clients, since this was the primary capacity in which they participated in the study. All participants were over 18 and currently living in the city of Prince George. Clients interviewed were mainly between 25 and 45; the majority (16 of 21) of clients interviewed reported having a regular health care provider, some in an Indigenous-led health organization and some not. 44 women and 21 men in total participated in interviews and focus groups.

Participants were asked to participate in a doctoral research study examining links between Indigenous rights and health care services, and if they consented to participate, were asked questions about their experiences with health care services in Prince George as well as how they felt that their rights were supported in health care in the city. Ethical approval for this research was obtained from the University of Toronto's Research Ethics Board as well as from the Northern Health Authority and the Prince George Native Friendship Centre.

Results

The barriers to accessing health services most frequently reported by participants were: quality of care; wait times; and experiences of racism and discrimination. These barriers are presented as distinct, but it is important to note that there is overlap among them. Direct quotations from clients, health services workers (HSWs), and focus groups (FGs) are attributed using numbers (e.g., Client 1; HSW 4; FG 2).

Quality of care

Nineteen participants, out of the total of 65, mentioned problems with quality of care, relating stories of how their needs had not been met in health care situations. Most of the issues raised about a perceived lack of quality of care related to delays in diagnosis of a health problem; denial of medication, in particular pain medication; delays in seeing a medical professional or lack of treatment altogether; or cases of serious neglect. Delays or mistakes in diagnosis were interpreted with great mistrust, suggesting that participants felt they were being deliberately mistreated or discriminated against. Participants reported having an understanding of the appropriate procedure or diagnosis, and not comprehending why these were not being undertaken. For example, one client explained:

I had an infection, and the doctor said it'll heal on its own, and I went to another doctor, and they said, 'you have an infection,' and I said, 'really?', and she put me on medicine right away.... This one doctor – she said it would heal on its own. And that kind of dis- appointed me, eh? ... I just – why did she do that? I said, 'oh, why did she make me feel that way for that long time?' (Client 17)

With respect to denial of medication, clients reported that health care providers deny them medication because of concerns about sub- stance misuse within the urban Indigenous population. Several participants reported living with chronic pain, and feeling that because they are Indigenous they face judgment and discrimination when asking for pain medication from a health care provider. One participant expressed a sense of

unfairness:

People with chronic arthritis, you know. It don't matter if you take it [pain medication] to feel good, at least you feel good and you're not paining, you know?... If they're hurting, I say help them. (Client 6)

In speaking about delays in seeing a health care provider or lack of treatment, participants felt that if they had not insisted on receiving care, they or their loved ones would have had serious consequences to their health. For example:

When [my mom's] appendix burst... she was, like, in the fricking... hallway [of the Emergency Department]... screaming – I've never seen her in so much pain... and I was like [to the health care providers], 'you need to fucking get over here, and you need to do something.' And they're like, 'oh, well she's in line, she's waiting,' I'm like, 'no.' I'm like, 'there's something wrong with her, like right now, she needs to see somebody now'... I was like, 'she's out here in this pain and you guys are just sitting here?'... Then they gave her some shots of morphine... and they gave her so much, they slowed down her heart rate. And I'm like, 'oh, you gave her too much,' and her heart rate started slowing down... when an appendix ruptures, all that poison can go in your body, right? And anaphylactic shock, and stuff like that, right? And here she's out there [in the hallway]. (FG 2)

With respect to cases of serious neglect when accessing health care services, many participants had heard stories in which Indigenous people died from neglect or suffered physical injury. For example, as one Elder – who has worked as a health care provider – described:

It's not just Prince George, I think it's all over. This guy in Burns Lake, he said his mom was in a nursing home. And she fell out of bed, broke her hip. And then she had bruises on her face, and her body. They have been really mean to her. It's not – I worked as a patient liaison for a while, eh? And I seen that first hand. (FG 3)

This account implies that the woman in question was abused during her stay at

the home. In addition, the way in which this participant takes a third-hand account and generalizes it spatially (“it’s all over”) as well as relating it to their own experiences (having seen it first hand) demonstrates the way this type of narrative tends to resonate with people and inform their own subsequent experiences in health care.

Overall, the responses in this theme reflect distrust of health care institutions on the part of Indigenous participants. Participants often reported feeling denied through not receiving adequate quality of care.

Wait times, wait lists, and restrictions on time

Eighteen of the 65 participants described long wait times as a barrier. Indigenous clients in this study interpreted long wait times or wait lists for services as a form of denial, in effect making services unavailable to them. Participants described: having an extended wait when accessing services at the Emergency department or walk-in clinics; having to schedule appointments weeks or months in advance; having to wait to be matched with a regular health care provider or for space in a treatment centre; or being put on a wait list for specialized services such as surgery or withdrawal management. For example, one participant described an experience waiting in the Emergency department:

P1: I had a tubal pregnancy... and it erupted but I didn't know it was a tubal pregnancy. And they just shut me in the Emergency room and just left me.... The next morning they take me in to do an ultrasound, and then it's like, 'oh my god, you're internally bleeding, and we need to go in for emergency surgery right now.'... The tube erupted, and they were soaking the blood out with towels, right? And so if they would have left me much longer–

P2: You would have bled to death. (FG 2)

Wait times are regarded as a barrier to life-saving treatment.

Health services workers focused more on appointment times. Many of these participants described taking extra time with Indigenous clients to facilitate their access to – and comfort with – the space and the services. As one health services worker said:

As an Aboriginal agency, we don't need to target, you know, one hour per

client – that's kind of what we're allotted, but you know what? If clients have different needs, if we need to advocate for them, we have the freedom to do that. (FG 3).

The above quote involves an implicit comparison with non-Indigenous health care institutions, in which this ability to allow for extra time is missing.

Other participants also referred to this lack of time for quality consultation in non-Indigenous health care. As one client put it:

The hospital's not really nice to you, but it's just like, they haven't got the time to deal with certain things or whatever, like, sit there and talk about whatever I need today, all these pains and stuff like that. (Client 9).

Overall, wait times and limitations on the time a client can spend with a provider are seen as significant obstacles to care for Indigenous people. Participants understood that the capacity of the health care provider or service may be limited, but still associated being made to wait with disrespect and unfairness. Wait times were seen as emblematic of a system that feels uncaring and disrespectful to Indigenous clients, in effect denying them care.

Perceived racism or discrimination

Sixteen of the 65 participants, both health care providers and Indigenous community members, described experiences of perceived racism or discrimination in health care based on Indigenous status, identity, or appearance. For example, one participant described wanting to find a new doctor because her current family physician “made a comment against Aboriginal people and I didn't like it” (Client 2). The same client described similar experiences at the hospital:

The only ones I found that were rude to me in the hospital, [were] the nurses. When I was in a lot of pain and I coughed, [one of the nurses] says, ‘cover your damn mouth.’ Like, oh my god. What kind of nurse are you? Because I was Native, I think that's – I just got that feeling, she's prejudiced. (Client 2)

Another client described feeling uncomfortable when filling prescriptions for

herself or her son:

Depends on which pharmacy you go to.... as soon as they see me, they always say, 'okay, how are you going to pay for this?' I find it... labeling [me as a First Nations person].... and I find them, I'm sure they don't mean to, but they always... make me feel like I'm lower than I am. As a person. Because they always ask, like, 'how are you going to pay for this? You even got money?' (Client 18)

Concerns about racism were raised by both clients and health services workers, but interestingly such concerns were voiced more strongly by both Indigenous and non-Indigenous health services workers. Clients appeared more reserved when talking about these experiences. For example, one health services worker said, "I don't think the system is borderline. I think the system is a racist system" (FG 2). Clients, on the other hand, accompanied descriptions of racist or discriminatory experiences with comments such as "I'm sure they don't mean to" (Client 18), or "it doesn't bother me anymore" (Client 5).

There was one client, a residential school survivor, who carried such anger at the way he was treated that he felt he had nothing to lose. He said, "when you don't care if you live or die, you're not afraid of anything" (Client 7). He spoke at length about the effects of colonialism and racism on Indigenous individuals and communities in Canada and emphasized the devastating impacts of these forms of oppression on people's health.

In some cases, instances of perceived racism or discrimination were described as discrimination against an Indigenous-led agency. For example, in the following quote one health services worker discussed concerns when not included in the shared care of a client she had already been seeing for some time:

I don't want to make the assumption that I wasn't being listened to because I'm from an Aboriginal agency. It did cross my mind. I don't know – that was never said... it just felt that... I was "Other," so whoever that could be. (FG 3)

Although Indigenous clients appeared to be at times more reluctant to discuss

issues of racism in health care, it was seen by both clients and health services workers as a significant barrier impacting Indigenous clients' access to health services.

Discussion and conclusions

The purpose of this study was to examine barriers to health care access for Indigenous peoples in light of broader structures of colonialism. Before discussing the key contributions of the research, a few limitations deserve mention. First, this study was carried out by a non-Indigenous researcher living outside of Prince George. This limitation has been mitigated through attention to Indigenous community research protocols; keeping in regular contact with people in Prince George; and reading daily headlines and articles in the Prince George newspaper. The small number of health care providers in this study may also be considered a limitation. However, the perspectives of health care providers are already the subject of research looking at the provision of health services for Indigenous people (Browne et al., 2016; Lavoie et al., 2015); this study's emphasis on client perspectives can be considered complementary to existing studies. Finally, the study's small, northern, urban setting raises questions about transferability of results. However, when one looks at the similarities in Indigenous people's experiences accessing health care services around the world, it seems likely that the results of this study can provide useful insight for other cities in Canada and internationally, especially in countries with settler colonial contexts.

Despite these limitations, results reveal key barriers to access to health services among Indigenous clients, including low quality of care; long wait times; and perceptions of racism and discrimination. Overall, participants felt they could not trust the system to provide the care they felt they needed; they felt they were made to wait even when urgently requiring services; and they associated many of these experiences with perceived racism or discrimination. Reading these responses through the lenses of cultural safety and ethical space provides important ways of understanding Indigenous participants' experiences in the context of settler colonialism.

Cultural safety is an important concept for interpreting power imbalances in health care because it emphasizes the need for health care institutions to critically

reflect on the colonial precedents of the care that they provide that contribute to these power imbalances. It promotes the provision of culturally as well as physically, mentally, and spiritually safe care that is culturally adaptable (Ramsden and Spoonley, 1994). In describing their own and others' experiences in health care, participants in this study outline feelings of denial and rejection, often linked to racism and discrimination, in the spaces of health care that lead to a sense of being unsafe, all of which are related to distinct power imbalances rooted in colonialism.

While cultural safety provides a framework through which to begin to understand these power imbalances, it does not provide a complete understanding on its own. In practice, cultural safety can be misunderstood (Gerlach, 2012). Operationalizing "culture" in health care proves difficult, often relying on superficial measures which may fall short of offering real decision-making power to culturally or racially marginalized patients (Browne and Varcoe, 2006; Waldram, 2009). Extending the framework of cultural safety using the concept of ethical space can help address these misunderstandings.

Ethical space is a legislative and philosophical framework elaborated by Cree scholar Willie Ermine to facilitate a meeting of world views between Indigenous and non-Indigenous cultures in North America (Ermine, 2007b). The framework is based in the concepts of both "ethics" and "space," describing a simultaneously philosophical, psychological, and physical space that is created when individuals who approach the world from differing perspectives meet. Ethical space encompasses the possibility that these differences in world view can be mutually explored. In the context of this study, participants describe differences in world view between themselves and health care providers, in that Indigenous clients often do not understand the reasons behind health care providers' actions. Both clients and health care providers carry experiences, orientations, and assumptions based in settler colonialism with them into the spaces of health care, setting up an incongruity in world view that creates a need for ethical space.

For example, the first barrier shows that the quality of care that Indigenous people in this study receive is often reported as substandard. This can create a negative feedback loop in which the experience of low quality care functions as a barrier to future

access by leading people to expect substandard care. Delayed or lower rates of accessing care may in turn lead to judgment on the part of health care providers, based on discourses that associate regular health care use with better responsibility for one's health (Leake et al., 2006). This in turn can increase clients' reluctance to access services. Further, many participants who discussed receiving inadequate care are dealing with chronic pain, the management of which is complex, requiring a balance among clear patient-provider communication; empathy on the part of the health care provider; and differing cultural understandings of pain, all with an undercurrent of suspicions surrounding potential misuse of pain medication (Jimenez et al., 2011). Research suggests that the decision to offer or withhold pain medication may more often be based on the appearance of a client than on clinical judgment (Browne et al., 2011). Studies also find that Indigenous peoples and other racialized groups tend to receive lower quality care for pain management, in spite of experiencing higher rates of chronic pain (Anderson et al., 2009). For Indigenous clients, health care institutions that provide substandard care can be seen as shirking ethical or moral responsibilities – both as health care providers with a responsibility to promote and protect health, and as governments in relationship with Indigenous peoples through treaties and the *Constitution Act*.

Participants' responses also lend themselves to a spatial analysis grounded in ethical space, in that they draw attention to boundaries drawn around the spaces of health care. Participants describe the spaces of non-Indigenous health care as being policed by gatekeepers – health care providers or other staff – who enforce seemingly arbitrary rules regarding who can enter the space and who must stay out. For example, the second barrier, long waiting times to receive care, can be easily dismissed as a concern that is common to everyone, not only Indigenous peoples (Canadian Institute for Health Information, 2017; Harrington et al., 2013; Sanmartin and Ross, 2006). Indigenous clients, however, may interpret extended wait times based on past experiences in health care or other government-led institutions (Hole et al., 2015). A situation in which a health care provider requires a client to arrive at the clinic on time, only to spend an unpredictable amount of time waiting, may reasonably be interpreted as the misuse of power for its own sake, something which Indigenous peoples and

communities have experienced much of throughout Canada's colonial history. Chronic and discriminatory underfunding of services, for example – related to health, child welfare, education, and other infrastructure and services – is a persistent experience for Indigenous communities in Canada (Blackstock, 2011; Lavoie et al., 2010). Wait times based on lack of capacity may therefore still be experienced as discriminatory for Indigenous clients.

By emphasizing ethics, ethical space focuses attention on the ways in which people *should* be treated, drawing out the moral obligation that health care providers and institutions have in caring for people in vulnerable positions. For example, the third and final barrier relates participants' experiences of racism and discrimination while receiving care, which acts as a significant impediment to participants' willingness to access services. Experiences of racism and discrimination make things like wait times and waiting lists seem like arbitrary rules intended to uphold colonial power over individual Indigenous peoples' lives. In turn, this puts up boundaries around health care settings that feel as though they are meant to keep Indigenous clients out. Ethical space is intended to break down these types of boundaries.

Many Indigenous clients in this study were more reluctant to discuss racism than health care providers, who were more outspoken about this barrier. There may be several reasons for this difference. It is likely that health care providers see, experience, or hear about more instances of racism and discrimination through their work, and as a result are able to perceive patterns and commonalities in the experiences of their Indigenous clients as well as in their own experiences. For clients, this difference in outspokenness may be related to perceived power differentials between the researcher and participants, which cause clients to feel that they are not authorized to offer critiques of the health care system. It may reflect past experiences such as in residential schools, in which clients may have experienced not being believed or listened to when critiquing the way they were being treated. Disturbingly, it may reflect a normalization of experiences of racism for clients who face such treatment on a regular basis. Or, it may reflect a strategy on the part of clients to reassert power in the face of discrimination that might otherwise make one feel powerless. Denial or downplaying of the power imbalances in health care settings, places the power to describe how such experiences

impact the client back in that person's own hands. There were exceptions to this – in particular one client who spoke at length about the effects of colonialism and racism on Indigenous individuals and communities in Canada and emphasized the fundamental, devastating impacts of these forms of oppression on people's health.

Ethical space, with its basis in legal frameworks and emphasis on colonialism at a societal scale, helps to make connections between health services, health systems policy and other aspects of the colonial system of government. It places the issues raised by participants (i.e., substandard quality of care, wait times, and racism and discrimination) in the context of what colonialism does to Indigenous individuals in their everyday lives, especially in encounters with government-led institutions such as health care. Understanding the colonial context in which these institutions have developed and now operate opens possibilities for re-imagining health care policy in Canada for Indigenous peoples, by keeping in mind the unique ways in which Indigenous peoples' experiences of colonialism are carried with them, perpetuated, and exacerbated within health care settings.

The Canada Health Act neither acknowledges federal responsibilities towards Indigenous peoples, nor addresses barriers to health care access experienced by Indigenous people. Federal health policy specific to Indigenous peoples should be incorporated into the CHA, and provinces and territories should take responsibility for Indigenous- focused health care in a more consistent manner. Call to Action 20 from the Truth and Reconciliation Commission of Canada (TRC) (2015) reads:

In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples. ([TRC, 2015](#))

Federal and provincial governments have a responsibility to work together to streamline policy and remove jurisdictional barriers to access to health care for all Indigenous peoples, including urban and off- reserve populations. Reading this responsibility through the lenses of cultural safety and ethical space draws attention to the power imbalances that have been created in health care policy for Indigenous

communities. Urban Indigenous clients and health care providers must be meaningfully included in any decisions surrounding changes to the Canada Health Act or federal health policy related to Indigenous peoples. Ethical space has been utilized as a framework in collaborations among Indigenous leaders and the federal, provincial and/or territorial governments, surrounding conservation of resources ([Alberta Energy Regulator, 2017](#)) – these prior experiences should be drawn on to inform discussions on changes to health care policy grounded in ethical space.

According to the results of this study, cultural safety and ethical space help to situate the barriers encountered by Indigenous participants in accessing health care in relation to the intrusion of colonial structures into Indigenous peoples' lives. The perspective provided by ethical space enhances cultural safety frameworks by broadening the focus to include more of the settler colonial context, and providing a spatial analysis that shows how settler colonialism intrudes into the spaces of health care for Indigenous clients.

Incorporating cultural safety and ethical space into policy and service delivery at both federal and provincial levels would greatly improve Indigenous clients' access to, and experiences in, health care settings. Ethical space shares the goals of cultural safety, in that it seeks to re-draw the lines of power in colonial and colonized society. If cultural safety can achieve the goals of making the spaces of health care approachable, acceptable, and safe for Indigenous people, ethical space might also make these spaces more just, in the sense that the relative power of different forms of knowledge might be equalized.

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